BY ORDER OF THE SECRETARY OF THE AIR FORCE

AIR FORCE INSTRUCTION 90-505

10 AUGUST 2012

Special Management

SUICIDE PREVENTION PROGRAM

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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Pages: 37

Supersedes: AFI44-154, 3 January 2003

This publication establishes requirements to conduct education and training to prevent acts of harm to self and raise awareness to prevent suicide and suicidal behavior in Air Force (AF) communities. This instruction implements AFPD 90-5, *Community Action and Information Board* and AFPD 44-1, *Medical Operations.* This instruction applies to all active duty Air Force and Air Reserve Component personnel, as well as the Air Force civilian employees specified herein. This AFI may be supplemented at any level, but all supplements must be routed to AFMSA/SG3OQ for coordination prior to certification and approval. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the AF Form 847, *Recommendation for Change of Publication*; route AF Form 847s from the field through the appropriate functional's chain of command. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with Air Force Manual (AFMAN) 33-363, *Management of Records*, and disposed of in accordance with Air Force Records Information Management system (AFRIMS) Records Disposition Schedule (RDS) located at **https://www.my.af.mil/afrims/afrims/afrims/rims.cfm**.

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Chapter 1

OVERVIEW

1.1. Purpose. To supports the Commander in cultivating a fit and ready force by reducing instances of self-directed violence.

1.2. Background.

1.2.1. In 1996, AF top leadership noticed a rise in suicide rates and commissioned an AF Suicide Prevention Integrated Product Team (IPT) to develop a comprehensive suicide prevention program to save lives. It was determined the entire AF community had to be invested in the process and the result.

1.2.2. A comprehensive, community-based suicide prevention initiative was developed which emphasized leadership involvement, community awareness, and promotion of an environment that encouraged Airmen in distress to seek-help. The AF Suicide Prevention Program (AFSPP) (described in **Chapter 3**) was one of the first efforts to apply a population health approach to suicide prevention.

1.3. Introduction.

1.3.1. Risk factors for suicide include relationship, legal, and financial problems, a history of a mental health diagnosis, substance misuse, and history of previous suicide attempts. Protective factors include social support and interconnectedness, belongingness, effective individual coping skills, and cultural norms that promote and protect responsible help-seeking behavior. Most of these risk and protective factors are modifiable.

1.3.2. Suicide is one extreme manifestation of psychosocial problems in the AF. A comprehensive suicide prevention program overseen by an effective Community Action and Information Board (CAIB) and Integrated Delivery System (IDS) must address the entire range of stressors and must consider the range of behaviors that negatively affect individuals, families and communities. Early intervention is always preferable to crisis response. A community-based approach is essential to reducing suicide and maintaining a fit and ready force. Effective suicide prevention also entails educating individuals about healthy/adaptive coping strategies, building confidence, and instilling a belief that members are indeed resilient and able to effectively overcome future life problems.

1.3.3. Monitoring is crucial for any effective suicide prevention program. The person most responsible for monitoring distress and individual effectiveness is the individual Airman. Next in line are the Airmen who serve to our left and to our right. An Airman's Wingmen are almost always in the best position to observe them on a daily basis and understand when subtle, or not so subtle, changes in attitudes or behavior should cause concern. We must continue to emphasize to our Airmen that the buddy system in regard to mental well-being is just as important as the buddy system in combat operations or medical care. Finally, as with most other areas in the Air Force, an Airman's chain of command has definitive responsibility for monitoring the fitness and effectiveness of their personnel. Leaders of all ranks have a vested interest in knowing their Airmen, investing in their professional and personal development, and quickly addressing any issues whenever they are identified

1.3.4. When leadership prioritizes suicide prevention, all Airmen prioritize suicide prevention. Leadership must establish a culture that strengthens social support for all Airmen, especially those in personal crisis. Leaders need to promote early help seeking and support those who ask for help. Commanders who promote preventive help seeking enhance the mission readiness of their Airmen.

Chapter 2

RESPONSIBILITIES

2.1. Air Force CAIB Chair (IAW AFPD 90-5).

2.1.1. Promotes an environment that encourages help-seeking and empowers Wingmen to intervene when peers are in distress.

2.1.2. Ensures the 11 Elements (described in **Chapter 3**) of the AFSPP are fully implemented.

2.1.3. Ensures training is conducted as detailed in **Chapter 4** and reviews training metrics.

2.1.4. Directs new initiatives in response to emerging trends from suicide data, research, and lessons learned.

2.1.5. Integrates suicide findings into the community health site picture and gives direction to the AF IDS to address emerging trends.

2.2. Air Force Surgeon General (AF/SG).

2.2.1. Serves as OPR for AFSPP in support of the AF CAIB.

2.2.2. Ensures clinical guidelines for managing suicidal patients are current and implemented.

2.2.3. Ensures *Airman's Guide for Assisting Personnel in Distress* (available at: **http://airforcemedicine.afms.mil/idc/groups/public/documents/webcontent/knowledgejunction.hcst?functionalarea=LeadersGuideDistress&doctype=subpage&docname=CTB_205851**) remains current.

2.2.4. Appoints a designated Air Force Suicide Prevention Program Manager (AFSPPM).

2.2.5. Ensures AFMOA/CC appoints Medical Incident Investigation (MII) in selected cases IAW AFI44-119, *Medical Quality Operations* when cases of Airmen dying of suicide are under the care of mental health professionals. The goals of the MII include determining if any system contributions to the adverse outcome exist and improve healthcare provision to reduce the risk of recurrence, thereby decreasing harm to patients.

2.2.6. Ensures a Department of Defense Suicide Event Report (DoDSER) entry is completed by a licensed behavioral health (BH) clinician or a mental health technician under the supervision of a licensed BH clinician within 30 days of the date of hospitalization or evacuation, or no later than 60 days of the date the event was determined to be a suicide for active duty service members and 90 days for guardsmen and reservists in title 10 status.

2.3. AF Deputy Chief of Staff for Manpower, Personnel and Services (AF/A1).

2.3.1. Provides policy and guidance for integrating and vetting new/emerging institutional education and training requirements or learning outcomes into accessions, Professional Military Education (PME), Professional Continuing Education (PCE) and ancillary training.

2.3.2. Ensures a system exists for tracking formal suicide prevention training.

2.3.3. Ensures Airman and Family Readiness Center staffs are trained to identify signs and symptoms of distress and know how to make an appropriate referral.

2.3.4. Supports the AFSPP by implementing an Air Force-wide comprehensive resilience initiative (e.g. Comprehensive Airman Fitness (CAF)) to help Airmen and their families withstand, recover, and grow in the face of stressors and changing demands.

2.3.5. Approves suicide prevention training requirements for insertion/inject into curriculum IAW AFI 36-2201, *Air Force Training Program* in coordination with the AFSPPM.

2.4. Air Force Deputy Chief of Staff for Logistics, Installations, and Mission Support (AF/A4/7).

2.4.1. Ensures appropriate and realistic resiliency-focused training on suicide prevention and reactionary police standard operating procedures for Security Forces Airmen through Security Forces technical training, on-the job training, advanced investigative training courses and internal threat exercise requirements. Standard operating procedure training includes response, hand-off, and reporting requirements (IAW SFMIS, AFMAN 31-201V7, *Security Forces Administration and Reports,* AFI31-201, Vol 4, *High-Risk Response*).

2.4.2. Delegates authority relating to incident reporting IAW DoD Directive (DoDD) 7730.47, *Defense Incident-Based Reporting System (DIBRS).*

2.4.3. Ensures compliance with hand-off policy IAW paragraph **3.1.6**

2.5. Air Force Office of Special Investigations (AFOSI).

2.5.1. Establishes policy and procedures for sharing information developed during AFOSI death investigations and for providing advice/consultation to the Wing DoDSER POC to ensure timely DoDSER completion for all deaths ruled to be a suicide by the Office of the Armed Forces Medical Examiner. Criminal investigations will always maintain primacy to DoDSER completion.

2.5.2. Ensures field agents support local DoDSER completion for suspected suicides investigated by AFOSI.

2.5.3. Ensures compliance with hand-off policy IAW paragraph **3.1.6**

2.5.4. Notifies the AFSPPM of suspected suicides.

2.6. Air Force Chief of Chaplains (AF/HC).

2.6.1. Ensures Chaplain Corps personnel are trained to provide suicide prevention interventions.

2.6.2. Ensures Chaplain Corps personnel are trained to provide appropriate postvention ministries in a manner that does not sensationalize, glamorize, romanticize, or give undue prominence to suicide to include:

2.6.2.1. Pastoral and spiritual care for distressed friends, family and coworkers.

2.6.2.2. Traumatic Stress Response (TSR) team membership.

2.6.2.3. Memorial and funeral services.

2.7. Inspector General of the Air Force (SAF/IG).

2.7.1. Evaluates implementation of the AFSPP's 11 Elements through Unit Compliance Inspections.

2.7.2. Ensures compliance with internal threat exercise requirements outlined in paragraph **2.4,** and hand-off policy IAW paragraph **3.1.6**

2.8. Air Force Staff Judge Advocate (AF/JA).

2.8.1. Ensures compliance with hand-off policy IAW paragraph **3.1.6**

2.8.2. Ensures all Judge Advocate personnel are trained in the Limited Privilege Suicide Prevention (LPSP) program IAW AFI 44-109, *Mental Health and Military Law*.

2.9. Director of Public Affairs, Office of the Secretary of the Air Force (SAF/PA).

2.9.1. Actively promotes the fitness, strength and resiliency of Airmen, in accordance with pertinent AF Public Affairs Guidance, including *AF Public Affairs Guidance for Suicide Prevention,* through coverage of stories related to overcoming personal challenges.

2.9.2. Creates, updates and coordinates pertinent AF Public Affairs Guidance, including *AF Public Affairs Guidance for Suicide Prevention;* ensures coordination across the Air Staff.

2.9.3. Distributes and ensures compliance with pertinent AF Public Affairs Guidance, including *AF Public Affairs Guidance for Suicide Prevention*.

2.9.4. Facilitates the engagement of AF senior leadership with the internal audience in accordance with pertinent AF Public Affairs Guidance, including *AF Public Affairs Guidance for Suicide Prevention.*

2.9.5. Ensures Public Affairs Airmen observe Active Shooter training in coordination with Security Forces, Office of Special Investigations and local medical personnel.

2.10. Air Force Medical Support Agency/Suicide Prevention Program Manager (SPPM) (AFMSA/SG3OQ).

2.10.1. Ensures standardized suicide prevention programs are developed in support of AFSPP goals.

2.10.2. Approves deviations from the approved AFSPP training requirements.

2.10.3. Maintains liaison with the Defense Centers of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury, Telehealth and Technology (T2) to ensure AF data is entered into the DoDSER database.

2.10.4. Establishes procedures for monitoring completion of DoDSER reports and provides feedback to Headquarters Air Force (HAF), Direct Reporting Units (DRU), AF Elements, MAJCOMs or Wings as appropriate.

2.10.5. Ensures a DoDSER entry is completed by a licensed BH clinician or a mental health technician under the supervision of a licensed BH clinician within 30 days of the date of hospitalization or evacuation, or no later than 60 days of the date the event was determined to be a suicide for active duty service members and 90 days for guardsmen and reservists in title 10 status.

2.10.6. Analyzes data entered in to the DoDSER database and reports standardized suicide metrics related to AFSPP goals to the AF CAIB/IDS.

2.10.7. Recommends designation of at-risk groups who will receive Tier 2 (see **Chapter 4**). training to the AF CAIB for approval annually.

2.10.8. Reviews, in consultation with CAIB/IDS agencies, cases forwarded by MAJCOMs or bases with possible AF-wide implications for briefing to the AF CAIB and/or HAF leadership.

2.10.9. Colloborates with national organizations, DoD, sister services, AF-level working groups, MAJCOM Behavioral Health consultants, and the DoD Suicide Prevention and Risk Reduction Committee (SPARRC) to share best practices and coordinate research initiatives.

2.10.10. Maintains currency on suicide prevention research and promotes AF-relevant research.

2.11. Air Force Personnel Center (AFPC and ARPC) Casualty Affairs Division.

2.11.1. Reports ARC and DAF civilian suicides to AF SPPM in a timely manner.

2.12. Commander, Air Education and Training Command (HQ AETC/CC).

2.12.1. Ensures suicide prevention education and training is developed and integrated into accessions, technical training, PCE and PME (as appropriate) at a degree/level of emphasis commensurate with grade and responsibility with the approval of the Air Force Learning Committee.

2.12.2. Ensures all new accessions will receive comprehensive face-to-face suicide prevention training**.**

2.12.3. Develops and distributes, in coordination with HQ USAF/SG, appropriate suicide prevention training materials for all levels of accession, technical training, and PME sources.

2.13. Superintendant, United States Air Force Academy.

2.13.1. Ensures suicide prevention education and training (as appropriate) is developed and integrated into accessions, technical training, PCE and PME at a degree/level of emphasis commensurate with grade and responsibility with the approval of the Air Force Learning Committee.

2.13.2. Ensures all new accessions will receive comprehensive face-to-face suicide prevention training**.**

2.13.3. Develops and distributes, in coordination with HQ USAF/SG, appropriate suicide prevention training materials for all levels of accession, technical training, and professional military education sources.

2.14. Major Command (MAJCOM) Commanders, ANG Director, Direct Reporting Unit CC, Forward Operating Agency CC.

2.14.1. Promotes an environment that encourages help-seeking and empowers Wingmen to intervene when peers are in distress.

2.14.2. Ensures suicide prevention training is conducted IAW **Chapter 4**.

2.14.3. Ensures each installation has a Total Force AFSPP.

2.15. MAJCOM CAIB Chair.

2.15.1. Promotes an environment that encourages help-seeking and empowers Wingmen to intervene when peers are in distress.

2.15.2. Ensures the 11 Elements of the AFSPP are fully implemented.

2.15.3. Ensures Tier 1 and Tier 2 suicide prevention training metrics (see Chapter 4) are reviewed and reported to the AF SPPM.

2.15.4. Directs new initiatives in response to emerging trends from suicide data, research, and lessons learned.

2.15.5. Ensures lessons learned with AF wide implications are shared with the AF SPPM.

2.15.6. Directs the MAJCOM IDS to implement action plan to address emerging trends related to suicide metrics within the MAJCOM.

2.16. Major Command Surgeon General (MAJCOM/SG), and ANG/SG.

2.16.1. Serves as OPR for AFSPP in support of the MAJCOM CAIB.

2.16.2. Ensures clinical guidelines for managing suicidal patients are implemented in the command.

2.17. Major Command Public Affairs (MAJCOM/PA, ANG/PA).

2.17.1. **Actively promotes the fitness, strength and resiliency of Airmen, in accordance with pertinent AF Public Affairs Guidance, including *AF Public Affairs Guidance for Suicide Prevention,* through coverage of stories related to overcoming personal challenges.**

2.17.2. Facilitates the engagement of MAJCOM senior leadership with the internal audience in accordance with pertinent AF Public Affairs Guidance, including *AF Public Affairs Guidance for Suicide Prevention.*

2.17.3. Ensures compliance with pertinent AF Public Affairs Guidance, including *AF Public Affairs Guidance for Suicide Prevention.*

2.17.4. Ensures Public Affairs Airmen observe Active Shooter training in coordination with Security Forces, Office of Special Investigations and local medical personnel.

2.18. Installation CAIB Chair.

2.18.1. Promotes a Total Force environment that encourages help-seeking and empowers Wingmen to intervene when peers are in distress.

2.18.2. Ensures the 11 Elements of the AFSPP are fully implemented.

2.18.3. Ensures Tier 1 and Tier 2 suicide prevention training metrics are reviewed and reported to the MAJCOM CAIB.

2.18.4. Directs new initiatives in response to emerging trends from suicide data, research, and lessons learned.

2.18.5. Ensures lessons learned from DoDSER data gathering processes are shared with the MAJCOM CAIB.

2.18.6. Integrates suicide findings into community health site picture and gives direction to the installation IDS to address emerging trends.

2.18.7. Ensures subject matter experts support suicide prevention training.

2.18.8. Ensures installation SG, unit leadership and AFOSI collaborate to complete a DoDSER entry on all suicides and SG and Unit leadership collaborate on DoDSER entries for all active duty non-fatal self-injurious behaviors with evidence of intent to die that result in hospitalization or evacuation from the Area of Responsibility (AOR). Ensures all required DoDSERs are completed within 30 days of the date of hospitalization or evacuation, or no later than 60 days of the date the event was determined to be a suicide for active duty service members and 90 days for guardsmen and reservists in Title 10 status.

2.19. Installation IDS Chair.

2.19.1. Ensures suicide prevention metrics are reported to the Installation CAIB IAW AFI 90-501: *Community Action and Information Board and Integrated Delivery System*.

2.19.2. Develops a comprehensive community suicide prevention outreach plan IAW AFI 90-501.

2.20. Installation Chaplain (HC).

2.20.1. Provides suicide prevention interventions within their scope of professional training.

2.20.2. Provides appropriate postvention ministries in a manner that does not sensationalize, glamorize, romanticize, or give undue prominence to suicide to include:

2.20.3. Provides pastoral and spiritual care for distressed friends, family and coworkers.

2.20.4. Serves as a Traumatic Stress Response (TSR) team member.

2.20.5. Conducts memorial and funeral services.

2.21. Installation Judge Advocate (JA).

2.21.1. Implements hand-off policy IAW paragraph **3.1.6**

2.21.2. Ensures all Judge Advocate and Mental Health personnel are trained annually in the legal aspects of the LPSP program (IAW AFI 44-109).

2.22. Installation Inspector General (IG).

2.22.1. Implements hand-off policy IAW paragraph 3.1.6.

2.23. AFOSI Detachment Commander (AFOSI Det/CC).

2.23.1. Implements hand-off policy IAW paragraph **3.1.6**.

2.23.2. Provides data to the Wing DoDSER POC regarding circumstances of death necessary to complete the DoDSER entry no later than 30 days of the date of hospitalization or evacuation, or within 60 days of the date the event was determined to be a suicide for active duty service members and 90 days for guardsmen and reservists in Title 10 status.

2.24. Installation Security Forces Squadron Commander (SF/CC).

2.24.1. Ensures security forces personnel engage in standard operating procedure training including response to internal and external threats, hand-off, and reporting requirements (IAW SFMIS, AFMAN 31-201V7, *Security Forces Administration and Reports,* AFI31-201, Vol 4, *High-Risk Response*).

2.24.2. Ensures compliance with hand-off policy IAW paragraph **3.1.6**.

2.25. Installation Public Affairs (PA).

2.25.1. Actively promotes the fitness, strength and resiliency of Airmen, in accordance with pertinent AF PA Guidance, including *AF Public Affairs Guidance for Suicide Prevention,* through coverage of stories related to overcoming personal challenges.

2.25.2. Facilitates the engagement of installation senior leadership with the internal audience in accordance with pertinent AF PA Guidance, including *AF Public Affairs Guidance for Suicide Prevention*.

2.25.3. Ensures compliance with pertinent AF PA Guidance, including *AF Public Affairs Guidance for Suicide Prevention.*

2.25.4. Ensures PA Airmen observe Active Shooter training in coordination with Security Forces, Office of Special Investigations and local medical personnel

2.25.5. Provides 24-hour alert photographer to local Security Forces personnel, Office of Special Investigations and local medical personnel for suicide documentation

2.26. Medical Treatment Facility Commander (MTF/CC) and ARC Medical Unit Commander.

2.26.1. Serves as OPR for AFSPP in support of the installation CAIB.

2.26.2. Ensures clinical guidelines for managing suicidal patients described in the *AF Guide for Managing Suicidal Behavior- Strategies Resources, and Tools* (available here: **http://afspp.afms.mil/idc/groups/public/documents/afms/ctb_016017.pdf**) are appropriately implemented.

2.26.3. Appoints in writing a suicide prevention program manager to support the AFSPP at the installation.

2.26.4. Ensures a DoDSER entry is completed by a licensed BH clinician or a mental health technician under the supervision of a licensed BH clinician within 30 days of the date of hospitalization or evacuation, or no later than 60 days of the date the event was determined to be a suicide for active duty service members and 90 days for guardsmen and reservists in title 10 status.

2.26.5. At ARC wings where no BH personnel are assigned, active duty mental health personnel (co-located wings) or a credentialed ARC flight surgeon or medical technician, under the supervision of a credentialed flight surgeon (ARC stand-alone wings), are authorized to complete a DoDSER.

2.27. Installation Suicide Prevention Program Manager/ DoDSER POC.

2.27.1. Provides consultation to commanders on unit-delivered training content (e.g. Frontline Supervisors Training and Wingman Day Suicide Prevention activities).

2.27.2. Serves as the OPR for implementation of suicide prevention training.

2.27.3. Ensures that a DoDSER is completed on required populations IAW paragraph **3.1.11.5**.-**3.1.11.10**.

2.28. Mental Health Flight Commander/ Director of Psychological Health.

2.28.1. Trains all investigative interviewers on the AF hand-off policy IAW paragraph **3.1.6**.

2.28.2. Assists commanders in identifying and referring members to Mental Health (MH) IAW AFI44-172.

2.28.3. Ensures a licensed mental health provider is available to provide consultation to Commanders and Wing/installation leadership on all mental health issues.

2.28.4. Ensures a licensed mental health provider is available to provide consultation to commanders after established duty hours. Offers recommendations on managing crisis situations to commanders, law enforcement agencies, first sergeants, and other helping agencies IAWAFI 44-172: *Mental Health*.

2.29. Squadron/Unit Commander.

2.29.1. Ensures an environment that promotes healthy/adaptive behaviors, fosters the Wingman culture, and encourages responsible help-seeking. Frequent messaging from senior AF leaders encourages unit Commander and supervisor involvement, which is critical to program success. Commanders ensure adequate resources, policy development, implementation, and efficacy.

2.29.2. Ensures all Airmen annually participate in suicide prevention training and provides documentation of these activities.

2.29.3. Engages appropriate helping agency or agencies if an Airman is in distress following an investigative interview.

2.29.4. Partners with base IDS agencies to provide services at the worksite; encourage help-seeking; and promote familiarity, rapport, and trust among Airmen and families.

2.29.5. Manages post suicide response and supports affected personnel through the grieving process, consulting with Chaplains and Mental Health as needed (see **Attachment 3**).

2.29.6. Provides necessary data to the Wing DoDSER POC following a suicide or suicide attempt to ensure DoDSER completion occurs no later than 30 days of the date of hospitalization or evacuation, or within 60 days of the date the event was determined to be a suicide for active duty service members and 90 days for guardsmen and reservists in title 10 status.

2.29.7. Engages appropriate helping agency or agencies if an Airman is in distress following an interview in which a rights advisement was given.

2.30. First Sergeant.

2.30.1. Engages appropriate helping agency or agencies if an Airman is in distress following an interview in which a rights advisement was given.

2.30.2. Ensures an environment which encourages Airmen to seek help when they are distressed.

2.31. Frontline Supervisor.

2.31.1. Ensures an environment which encourages Airmen to seek help when they are distressed.

2.31.2. Develops a relationship of trust with his or her unit, learn signs of distress, effective ways to discuss issues with subordinates, and where to refer should additional resources be needed.

2.31.3. Recognizes and effectively intervenes with personnel suffering from emotional distress secondary to a variety of life problems.

2.31.4. New active duty frontline supervisors working with at-risk groups will complete the required frontline supervisor training within 90 days of assuming supervisory responsibility. If the supervisor deploys during the initial 90-day window, the supervisor will complete the required training within 90 days of return.

2.31.5. New ARC frontline supervisors working with at-risk groups will complete the required frontline supervisor training within 365 days of assuming supervisory responsibility. If the supervisor deploys during the initial 365-day window, the supervisor will complete the required training within 180 days of return.

2.32. Unit Training Monitor (UTM).

2.32.1. Reports metrics regarding participation in annual suicide prevention training to the unit commander.

2.33. Airman.

2.33.1. Maintains awareness of the signs/symptoms of Airmen in distress and promotes help-seeking in distressed peers using the Ask, Care, Escort (ACE) model.

2.33.2. Serves as a role model by actively implementing AF Core Values and practicing healthy behaviors**.**

2.33.3. Develops other Airmen as part of a fit and ready force**.**

2.33.4. ARC Airmen recognize the unique challenges of being a Citizen Airman and practice healthy behaviors to maintain readiness at a moment's notice. When not with the unit, recognize it takes even more initiative and integrity to practice active self and buddy care.

Chapter 3

PROGRAM

3.1. AFSPP 11 Elements.

3.1.1. Leadership Involvement.

3.1.1.1. Leaders build an environment that promotes healthy/adaptive behaviors, fosters the wingman culture, and encourages responsible help-seeking. Frequent messaging from senior AF leaders encourages unit commander and supervisor involvement, which is critical to program success. Commanders ensure adequate resources, policy development, implementation, and efficacy.

3.1.2. Addressing Suicide Prevention through Professional Military Education (PME).

3.1.2.1. PME provides periodic and targeted Suicide Prevention training for Airmen, specifically oriented to the individual's rank and level of responsibility. Leaders will understand what policies and practices promote or discourage help-seeking, and develop skills to detect at-risk individuals and intervene with Airmen under stress.

3.1.3. **Guidelines for Commanders: Use of Mental Health Services.**

3.1.3.1. Commanders are encouraged to partner and consult with the mental health staff about the health of their Airmen to improve their duty performance. Early self-referral yields the best outcome for the individual and the unit; however, there are circumstances when commanders must order a member to the MTF for a Mental Health evaluation (IAW AFI 44-109), substance abuse assessment (IAW AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program*), or family advocacy issues (IAW AFI 40-301, *Family Advocacy*). Commanders must be aware of the legal implications of different types of referrals and consult with the legal office as needed. ARC commanders will be familiar with available mental health options.

3.1.4. Unit-based Preventive Services.

3.1.4.1. Helping-agency professionals partner with unit leaders to provide services at the worksite to increase access; encourage help-seeking; and promote familiarity, rapport, and trust with Airmen and families. These services also improve unit cohesion and effectiveness.

3.1.5. Wingman Culture.

3.1.5.1. Wingmen practice healthy behaviors and make responsible choices and encourage others to do the same. Wingmen foster a culture of early help-seeking. Wingmen recognize the signs and symptoms of distress in themselves and others and take protective action.

3.1.6. **Investigative Interview Policy (Hand-off Policy).**

3.1.6.1. Airmen facing criminal or administrative action are at increased risk for suicide. They can easily feel isolated from family, friends, and other social supports when needing them most.

3.1.6.2. Following an investigative interview, the AF investigators (i.e., AFOSI, IG, SF, and MEO) are required to hand-off the accused directly to the member's commander or first sergeant through person-to-person documented contact. For ARC units, when the commander or first sergeant is a traditional guardsman/ reservist and unable to be contacted, the senior ranking unit member (E-7 or higher) on active status will receive person-to-person contact and in turn make notifications to the first sergeant and commander. The investigator will notify the unit representative that the individual was interviewed and is under investigation.

3.1.6.3. When an investigating agent believes the member may present a risk of suicide, he/she shall communicate that concern to the member's commander or first sergeant, who will then consider making a referral for a Mental Health evaluation and possible placement in the LPSP program.

3.1.6.4. The commander or first sergeant is responsible for determining the member's emotional state and contacting a mental health provider if they suspect a risk of suicide.

3.1.7. Post-Suicide Response (Postvention).

3.1.7.1. Suicide impacts coworkers, families, and friends. Offering support early is associated with increased help-seeking behavior. Post-suicide responses are managed by unit leaders. Unit leaders support affected personnel through the grieving process, consulting with chaplains and mental health as needed.

3.1.7.2. Care must be taken to avoid sensationalizing, glamorizing, romanticizing or giving undue prominence to suicide. These practices are associated with suicide clusters, copycat suicides, and increased suicide rates. Following a suicide, unit leaders and helping professionals should reference AF post-suicide guidance (see **Attachment 3**).

3.1.8. CAIB and IDS.

3.1.8.1. CAIB and IDS provide a forum for the cross-organizational review and resolution of individual, family, installation, and community issues that impact the readiness of the force and the quality of life for Airmen and their families. The CAIB and IDS help coordinate the activities of the various military and non-military helping agencies to achieve a synergistic impact on community problems and reduce suicide risk IAW AFI 90-501. Emphasizing suicide prevention at the CAIB makes IDS initiatives at the Wing, MAJCOM, and AF-levels more targeted and effective.

3.1.9. LPSP Program.

3.1.9.1. Members under criminal or administrative investigation are at increased risk for suicide. To encourage this high risk group to seek help, LPSP Program affords increased legal protections and confidentiality. Members in this program are granted limited protection with respect to the information revealed during or generated by their clinical relationship with the mental health professional.

3.1.9.2. It is important that providers, patients, and commanders understand the limited nature of LPSP protection. Information in the LPSP mental health file can be disclosed to other medical personnel for purposes of medical treatment, a member's confinement military commander, for legal proceeding against third parties and to other authorized personnel with an official need to know (e.g., commanders) IAW AFI 44-109.

3.1.10. Commander Consultation Tools.

3.1.10.1. Use of validated unit climate assessment tools is an excellent way for commanders to tap into the strengths and challenges within their organizations. Results from these instruments can assist commanders in choosing strategies to enhance the wellbeing and resilience of their Airmen.

3.1.10.2. A number of assessment tools are currently available to all commanders at no cost to the unit. Some of these include the Equal Opportunity's Unit Climate Assessment, the Support and Resilience Inventory (SRI), and the Air Force Culture Assessment Safety Tool.

3.1.10.3. Local IDS team members can help commanders select the best instrument for their unit. Additionally, IDS agencies can help interpret the results of the chosen tool and assist in developing a plan to leverage the strengths of our Airmen and address unmet needs within our units.

3.1.11. Suicide Event Tracking and Analysis.

3.1.11.1. Information on all AF suicides and suicide attempts are entered into a central database, currently the DoDSER, to identify suicide risk factors and trends. Collective analyses of useful findings are disseminated AF-wide for local application.

3.1.11.2. This publication requires the collection and or maintenance of information protected by the Privacy Act (PA) of 1974. The authorities to collect and or maintain the records prescribed in this publication are Title 10 *United States Code*, Section 136 and 10 U.S.C. 8013, Secretary of the Air Force; 10 U.S.C. 5013.

3.1.11.3. In addition to those disclosures generally permitted under 5 U.S.C. 552a (b) of the Privacy Act of 1974, these records, or information contained therein, may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a (b) (3) as follows:

Statistical summary data with no personally identifiable information may be provided to federal, state, and local governments for health surveillance and research.

3.1.11.4. The DoD Blanket Routine Uses published at the beginning of the Office of the Secretary of Defense compilation of record system notices apply to this system, except as stipulated in Notes below.

3.1.11.5. For suspected suicides of active duty or equivalent ARC members, data collection and post-suicide assessments will be completed at the decedent's installation. This review process will collect and report information to comply with the DoDSER requirements, established in 2008 by the Undersecretary of Defense for Personnel and Readiness.

3.1.11.6. A DoDSER will be completed for the following groups:

3.1.11.6.1. All Airmen in Title 10 status who die by suicide or attempt suicide.

3.1.11.6.2. Active full time ANG personnel (Title 32) who die by suicide.

3.1.11.7. Basic demographic data (DoDSER data fields 1-9), at a minimum, will be tracked on the following populations:

3.1.11.7.1. All Department of the Air Force civilian employee personnel who die by suicide.

3.1.11.7.2. All Selected Reserve (SELRES) and traditional ARC members who die by suicide.

3.1.11.8. MAJCOM, FOAs, DRUs and the ANG have the authority to conduct additional reviews on suicides by civilians and reserve members not in Title 10 status within their commands.

3.1.11.9. A DoDSER will be completed for suicide attempts no later than 30 days of the date of hospitalization or evacuation, or within 60 days of the date the event was determined to be a suicide for active duty service members and 90 days for guardsmen and reservists in title 10 status (ARC personnel refer to para **3.1.11.10**)

3.1.11.10. At ARC wings where no BH personnel are assigned, active duty mental health personnel (co-located wings) or a credentialed ARC flight surgeon or medical technician, under the supervision of a credentialed flight surgeon (ARC stand-alone wings), are authorized to complete a DoDSER.

3.1.11.11. For reportable events that occur in a deployed setting the DoDSER will be completed at the service member’s home station.

Chapter 4

EDUCATION AND TRAINING

4.1. Suicide Prevention. Suicide prevention training will be delivered to Airmen through a tiered and targeted approach.

4.1.1. Tier 1: Foundational Training.

4.1.1.1. All new Airmen will receive suicide prevention training during accessions through a face-to-face format. Upon training completion, Airmen will identify and mitigate risk factors for suicide.

4.1.1.2. First Term Airmen's Center (FTAC) attendees will also receive face-to-face training IAW AFI 36-2624, *The Career Assistance Advisor*, *First Term Airmen Center and Enlisted Professional Enhancement Programs*.

4.1.1.3. All Airmen will complete annual Total Force Awareness Training (TFAT) (IAW AFI 36-2201). This training provides information about how to identify and assist others at risk for suicide and how to help them. The program identifies and emphasizes protective factors, the benefit of seeking help early in the development of life problems, and the benefit of engaging in health-promoting activities. The program helps identify and mitigate risk factors for suicide, and increase the protective factors for AF personnel (see **Attachment 2**). The minimum requirement for TFAT is computer based training (CBT), however unit commanders are highly encouraged to conduct suicide prevention training face-to-face using the CBT slides to facilitate small group discussions. Unit commanders who opt for face-to-face annual training must ensure that unit UTMs document this training in ADLS using the offline course completion tool.

4.1.2. **Tier 2: Targeted Training for At-Risk Groups.**

4.1.2.1. At-risk groups, designated by the AF CAIB, will complete face-to-face annual suicide prevention training, in lieu of CBT.

4.1.2.2. Supervisors of Airmen in at-risk groups will attend a one-time Frontline Supervisors Training (FST).

4.1.2.3. New supervisors in these fields will complete the required training within 90 days of assuming supervisory responsibility. If the supervisor deploys during the initial 90-day window, the supervisor will complete the required training within 90 days of return.

4.1.2.4. New ARC frontline supervisors working with at-risk groups will complete the required frontline supervisor training within 365 days of assuming supervisory responsibility. If the supervisor deploys during the initial 365-day window, the supervisor will complete the required training within 180 days of return.

4.1.3. **Tier 3: Managing Personnel in Distress.**

4.1.3.1. Personnel in agencies with high probability for encountering personnel in distress (e.g., AFOSI, mental health, security forces, Judge Advocate, chaplains, Airman

and Family Readiness Center, commanders, and first sergeants) will complete agency-specific training on appropriate intervention and referral procedures.

4.1.3.2. Mental Health Flight, ANG DPH or designated ARC personnel will provide training to AF investigative agency personnel on LPSP, investigative interview hand-off procedures, and accessing local emergency services. Active duty training is required within 30 days of reporting for assignment at a new duty location, ARC training is required within 60 days of reporting at a new duty location.

4.1.3.3. All mental health providers will complete annual training on the AF clinical guidelines for managing suicidal behavior.

Chapter 5

METRICS

5.1. Suicide Prevention Training Metrics.

5.1.1. **Demographic and epidemiological data on suicide and suicide attempts will be updated annually and obtained directly from the AF Institute for Environment, Safety and Occupational Health (ESOH) Risk Analysis, Telehealth and Technology (T2).**

5.1.2. Completion of Frontline Supervisor Training by supervisors in groups designated by the AF CAIB Chair will be reviewed quarterly by the Installation SPPM and the Installation CAIB as needed. The Installation CAIB forwards annual FST metrics to the MAJCOM CAIB. The MAJCOM CAIB will aggregate FST metrics and forward to the AFSPPM annually.

5.1.3. Completion of suicide prevention training and FST will be documented in the Advanced Distance Learning System (ADLS). Unit Training Managers (UTM) will track training completions for unit personnel and provide statistics upon request to the installation SPPM for review and action as necessary. The CAIB will ensure the installation metrics are forwarded to the MAJCOM CAIB/IDS and the MAJCOM Behavioral Health Consultant (BHC). The MAJCOM BHC will forward the data to AFMSA/SG3OQ as described below.

5.1.4. ANG/SG will track the accomplishment of suicide prevention training requirements for the ANG on an annual basis. ANG/SG will also provide a copy of these results to NGB/HQ.

5.1.5. Each MAJCOM CAIB will track the accomplishment of suicide prevention training total force requirements and will report currency data to HQ AFMSA/SGO3OQ for each calendar year, within 31 days of its close.

5.1.6. MAJCOM military and civilian training will be reported by the command-appointed SPPM. Reports will include training data that are collected on a quarterly basis from the IDS to address the following metrics: Trained Personnel Requirement (TPR), Total Personnel Current (TPC), and Percentage Current. MAJCOMs will report aggregate data from installation-level data to the AF CAIB/IDS for each metric in a spreadsheet format.

5.2. Statistics Available to Support Total Force Education:

5.2.1. The Office of the Armed Forces Medical Examiner (OAFME) maintains and forwards summary statistics, updated on a quarterly basis, to AFMSA/SG3OQ, which reflect the epidemiological perspective of Air Force suicide rates, attempt rates, and associated risk and protective factors for Airmen in Title 10 stats. AFRC, ANG, and AFPC will provide training statistics only; reliable epidemiological data are not available on suicides or nonfatal self-injuries that occur for civilian employees or while RC members are on civilian status.

5.2.2. DoDSER is the official database for active duty suicides and suicide attempts. This integrated data will be available for use at MAJCOM and wing-levels in support of their training *and intervention efforts.*

LARRY O. SPENCER , General USAF
Vice Chief of Staff

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

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Adopted Form

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Abbreviations and Acronyms

ACE—Ask, Care, Escort

ADLS—Advanced Distance Learning System

AFI—Air Force Instruction

ANG—Air National Guard

AFOSI—Air force Office of Special Investigations

AFR—Air Force Reserve

AFSPP—Air Force Suicide Prevention Program Manager

AOR—Area of Responsibility

ARC—Air Reserve Component

ARPC—Air Reserve Personnel Center

AU/CC-SG—Air Force Surgeon General Chair to the Air University

BH—Behavioral Health

BHC—Behavioral Health Consultant

CAF—Comprehensive Airman Fitness

CAIB—Community Action Information Board

CBT—Computer-Based Training

CPF—Civilian Personnel Flight

DPH—Director of Psychological Health

DoDSER—Department of Defense Suicide Event Report

FAO—Family Advocacy Office

FST—Frontline Supervisors Training

FTAC—First Term Airmen Center

GSU—Geographically Separated Unit

HAF—Headquarters Air Force

IDS—Integrated Delivery System

IPT—Integrated Product Team

LPSP—Limited Privilege Suicide Prevention

MAJCOM—Major Command

EO—Equal Opportunity

MH—Mental Health

MII—Medical Incident Investigation

NAF—Numbered Air Force

NGB—National Guard Bureau

NOK—Next of Kin

OAFME—Office of the Armed Forces Medical Examiner

OPR—Office of Primary Responsibility

PA—Public Affairs

PAG—Public Affairs Guidance

PCM—Primary Care Manager

PME—Professional Military Education

POC—Point of Contact

RC—Reserve Components

SELRES—Selected Reserve

SFS—Security Forces Squadron

SPARRC—Suicide Prevention and Risk Reduction Committee

SPPM—Suicide Prevention Program Manager

T2—Telehealth

TFAT—Total Force Annual Training

TSR—Traumatic Stress Response

UTM—Unit Training Manager

Terms

Air Force Personnel/Airman—Active duty, Air National Guard, AF Reserve personnel, and civilian employees of the United States Air Force.

At-Risk—Designates individuals displaying risk factors that potentially place them at some risk for self-harm.

Buddy Care—Individuals taking care of their buddies, friends, or co-workers. Relating to suicide prevention, it means co-workers learning what risk factors to look for, and bringing at-risk individuals to the attention of their supervisor.

Community—Military and civilian personnel assigned to an AF installation or organization, their families, attached Reserve and Guard units, and retirees who utilize base services.

DoD Suicide Event Report (DoDSER)—A comprehensive, 250 item database maintained by Defense Centers of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury Telehealth and Technology (T2) available at **https://dodser.t2.health.mil/dodser/intro.html**.

Helping Professionals—Includes, but is not limited to, Mental Health, Chaplains, Family Support, Family Advocacy, Law Enforcement, Legal, Health Promotion, Substance Abuse, Drug Demand Reduction, Equal Opportunity, Youth Programs, and Senior Enlisted Advisor personnel.

Imminently Dangerous—A clinical finding or judgment by a privileged, doctoral-level Mental Health provider based on a comprehensive Mental Health evaluation that an individual is at substantial risk of committing an act or acts in the near future that would result in serious personal injury or death to himself, herself, another person or persons, or of destroying property under circumstances likely to lead to serious personal injury, or death, and that the individual manifests the intent and ability to carry out that action. A violent act of a sexual nature is considered an act that would result in serious personal injury.

Integrated Delivery System—The coordinating body, usually working as a committee within the Community Action Information Board, that integrates community-based helping resources.

Leadership Personnel—All personnel in leadership or supervisory positions or who are responsible for services to improve the welfare and/or development of others. This would include, but not be limited to, Commanders, First Sergeants, and supervisory members in the rank of Staff Sergeant or GS-7 and above.

Limited Privilege Suicide Prevention Program—Air Force members enrolled in the LPSP program are granted limited protection with regard to information revealed in, or generated by their clinical relationship with MHPs IAW AFI 44-109. Such information may not be used in the existing or any future UCMJ action or when weighing characterization of service in a separation. Commanders or persons acting under their authority, such as staff judge advocates, squadron executive officers, or first sergeants, may use the information for any other purposes authorized by law, this instruction, and other Air Force instructions and programs.

Protective Factors—Protective factors reduce the likelihood of suicide. They enhance resilience and may serve to counterbalance or mitigate the effects of risk factors.

Reserve Components—Reserve Components of the Armed Forces of the United States are: a. the Army National Guard of the United States; b. the Army Reserve; c. the Naval Reserve; d. the Marine Corps Reserve; e. the Air National Guard of the United States; f. the AF Reserve; and g. the Coast Guard Reserve.

Reportable Event—Any death determined by the Office of the Armed Forces Medical Examiner to be a suicide or any self-injurious behavior consistent with the definition of a suicide attempt.

Risk Factors—Includes, but is not exclusively limited to, such factors as relationship difficulties, substance abuse, legal, financial, medical, mental health, and occupational problems, along with depression, social isolation, and previous suicide threats/gestures which may increase the probability of self-harm.

Suicide Attempt—Any non-fatal, self-injurious behavior which is accompanied by evidence of intent to die and results in hospitalization or evacuation from the AOR. (Note: Hospitalization or evacuation must be the result of the self-injurious behavior, not accompanying suicidal ideation.)

Suicide Prevention and Risk Reduction Committee— The SPARRC provides a forum for the Departments of Defense and Veterans Affairs to partner, collaborate and coordinate suicide prevention and risk reduction efforts. Members include suicide prevention program managers from each of the services and representatives from the National Guard Bureau, Reserve Affairs, VA, Office of Armed Forces Medical Examiner, National Center for Telehealth and Technology, Substance Abuse and Mental Health Services Administration and others.

Trained Personnel Requirement—Total number of installation personnel requiring training.

Total Personnel Current—Number of personnel whose training is current during the calendar year in question.

Attachment 2

SUICIDE PREVENTION TRAINING CURRICULUM OUTLINE

This lesson content outline is a suggested basic framework for training. IDS member trainers are encouraged to be both active participants and innovative in the delivery of training, using role-play, multimedia resources, and creative approaches to accomplish training objectives.

Part I: Introduction and Overview

A. Goal for Suicide Prevention Training Program:

1. All Airmen will be able to recognize signs and symptoms of distress in themselves and others.

2. All Airmen will be prepared to intervene using the A.C.E. model when they recognize distressed Wingmen.

B. Suicide in the AF

1. Percentage of AF deaths attributed to suicide

2. Number and rate of USAF suicides

3. Tailor available suicide statistics as appropriate

C. Responsibility to self and community

1. Suicide is the second leading cause of death in the AF after deaths due to accidents

2. Suicide prevention is the responsibility of the entire AF community

D. Quality-of-life exists on a continuum

1. All persons experience problems

2. Ability to cope and problem-solve:

a) Extent, duration, and intensity of problem

b) Nature of problem

c) Social support network

d) Spiritual beliefs

e) Personal resilience

f) Physical health

g) Emotional reserves

E. Protective factors

1.Publications and forms are available for downloading or ordering on the e-Publishing website at **www.e-Publishing.af.mil** Coping skills and problem-solving skills

2. Self-efficacy

3. Sense of optimism

4. Willingness to talk about problems

5. Sense of belonging to a group and/or organization

6. Strong Social/community/family support

7. Belief that it is okay to ask for help

8. Spiritual/religious affiliation

9. Easily accessible helping resources

F. Risk factors

1. Relationship stress

2. Financial stress

3. Legal problems

4. A history of past abuse

5. Substance abuse

6. Mental health problems

7. A sense of powerlessness/helplessness/hopelessness

8. Negative social interactions

9. Academic and other life failures

10. History of suicide attempts

11. Recent loss

12. Severe, prolonged, or unmanageable stress

13. Major life transitions

14. Belief there is no solution or no way out

15. Sense of being a burden to others

Warning Signs

G. Key points

1. Indicator of vulnerability vs. being predictive of a probability of suicide

2. Conditions of vulnerability may indicate a variety of other mental/physical Problems

3. The balance between protective factors and modifiable risk factors

a) Every person is at some risk

b) Key for suicide prevention: increase protective, decrease risk

Part II: Self-care

A. Sources and types of help available

1. Chaplain

2. Airman and Family Readiness Center

3. Health and Wellness Centers

4. Mental Health Clinic

5. Family, friends, supervisors/leaders

6. Suicide Prevention Hotline: **1-800-273-TALK**

7. Emergency department and 911

B. Advantages and perceived barriers of seeking help

1. The benefit of dealing with stress and life's problems early

2. Common concerns

a) Security status

b) Special duty status (e.g., flying, Personnel Reliability Program (PRP))

c) Weapons bearing status

d) Confidentiality

3. For most Airmen who seek mental health care, their privacy is maintained and their career is unharmed

a) Almost all Airmen who seek treatment at AF Mental Health Clinics suffer no negative career impact

b) For most Airmen who seek mental health care, no one from the unit is ever contacted and their privacy is maintained

c) When Commanders are contacted, they're only given fitness for duty and safety information

C. Indicators that "I" might want to seek help

1. High or persistent stress leading to problems in everyday living

a) Types of stress

b) Symptoms of too much stress

c) Difficulty coping

d) Difficulty functioning

2. Thoughts about suicide

Part IV: Buddy-care

A. When to be concerned about a colleague/buddy

1. Misconceptions/myths

2. ACE: When talking with someone showing risk factors for suicide, think of the acronym "ACE."

a) A - Ask your wingman

i.) Have the courage to ask the question, but stay calm

ii.) Ask the question directly: "Are you thinking of killing yourself?"

b) C - Care for your wingman

i.) Calmly control the situation, do not use force, be safe

ii.) Actively listen to show understanding and produce relief

iii.) Remove any means that could be used for self-injury

c) E - Escort your wingman

i.) Never leave your buddy alone

ii.) Escort to chain of command, Chaplain, behavioral health professional, or primary care provider

iii). Call the **National Veteran's Crisis Line:** 1-800-273-8255 (TALK)

B. Approaches to communication

1. Do(s)

a) Share your concerns

b) Ask about thoughts/plans for suicide

c) Be direct and honest

d) Use open-ended questions

e) Listen

f) Express caring and hope

2. Don't(s)

e) Give advice

f) Be judgmental

g) Lecture or debate

h) Dare them to do it

i) Act shocked

j) Leave them alone

k) Promise secrecy

C. Restricting access to lethal means

1. Firearms

2. Alcohol/pills

3. Automobiles

4. Rope

Attachment 3

AF LEADER'S POST SUICIDE CHECKLIST

AF Leader's Post-Suicide Checklist	
Purpose: This checklist is designed to assist leaders in guiding their response to suicides and suicide attempts. Research suggests the response by a unit's leadership can play a role in the prevention of additional suicides/suicide events or, in worst cases, inadvertently contribute to increased suicides/suicide attempts (suicide contagion). This checklist is intended to augment any local policies. It incorporates "lessons learned" from leaders who have experienced suicide deaths in their unit. It is a guide intended to support a leader's judgment and experience. The checklist does not outline every potential contingency which may come from a suicide or suicide attempt. A second checklist, Guidance for Actions Following a Suicide Attempt, is attached at the end of this section.	
Guidance for Actions Following a Death by Suicide	
1	Contact local law enforcement/Security Forces, AFOSI, and 911 (situation dependent). AFOSI Duty Agent can be contacted after hours through the Law Enforcement Desk or Command Post.
2	Notify First Sergeant, Command Post and Chain of Command. Command Post will initiate Operational Reporting (OPREP) messages. (Command Post will notify FSS/CL and Mortuary Affairs.)
3	Notify Mental Health Clinic or Mental Health on-call provider, or ARC equivalent, to prepare activation of the Traumatic Stress Response (TSR) Team. Command Post can assist with contacting Mental Health after duty hours.
4	Validate with JA and AFOSI who has jurisdiction of the scene and medical investigation. Normally, local medical examiners/coroners have medical incident authority in these cases but some locations may vary.
5	Contact Casualty Assistance Representative (CAR) to notify Next of Kin (NOK) IAW AFI 36-3002, *Casualty Services* and receive briefing on managing casualty affairs. Wing Commander or office designee makes notification if NOK is in local area. CAR can assist.
6	Consult with TSR Team Chief or on-call Mental Health provider to prepare announcement to unit and co-workers. ***Review Air Force Leader's Guide for Post-Suicide Response PowerPoint*** (available at: https://kx.afms.mil/kxweb/dotmil/file/web/ctb_215563.pdf) ***for just-in-time considerations offered by other leaders and key components of post-suicide programming.***
7	Make initial announcement to work site with a balance of "need to know" and rumor control. Consider having TSR team members present for support to potentially distraught personnel, but avoid using a "psychological debriefing" model. Make initial announcement to work site/unit.
8	Consult with Public Affairs regarding public statements about the suicide and refer to the Public Affairs Guidance (PAG) for Suicide Prevention.
9	When speaking to the work site/unit, avoid announcing specific details of the suicide, merely state it was a suicide or reported suicide. Do not mention the method used. Location is announced as either on-base or off-base. Do not announce specific location, who found the body, whether or not a note was left, or why the member may have killed himself
10	Avoid glorifying/idealizing deceased or conveying the suicide is different from any other death. Consult with Mental Health, the Chaplain, and your mentors/Chain of Command for any actions being considered for memorial response.

11	When engaging in public discussions of the suicide: 1) Express sadness at the Air Force's loss and acknowledge the grief of the survivors; 2) Emphasize the unnecessary nature of suicide as alternatives are readily available; 3) Express disappointment that the Airman did not recognize that help was available; 4) Ensure the audience knows you and the Air Force want personnel to seek assistance when distressed, including those who are presently affected; 5) Encourage Wingmen to be attuned to those who may be grieving or having a difficult time following the suicide, especially those close to the deceased; and 6) Provide brief reminder of warning signs for suicide.
12	After death announcement is made to the work center, follow-up your comments in an e-mail provided to the community affected. Restate the themes noted above.
13	Unless you discern there is a risk of being perceived as disingenuous, consider increasing senior leadership presence in the work area immediately following announcement of death. Engage informally with personnel and communicate message of support and information. Presence initially should be fairly intensive and then decrease over the next 30 days to a tempo you find appropriate.
14	Consult with Chaplain regarding Unit Sponsored Memorial Services. Memorial services are important opportunities to foster resilience by helping survivors understand, heal, and move forward in as healthy a manner as possible. However, any public communication after a suicide, including a memorial service, has the potential to either increase or decrease the suicide risk of those receiving the communication. It is important to have an appropriate balance between recognizing the member's military service and expressing disappointment about the manner of death. If not conducted properly, a memorial service may lead to adulation of the suicide event and thus potentially trigger "copy cat" events. Therefore, memorial services should avoid idealizing the deceased or the current state of peace found through death. Avoid normalizing suicide by inferring it is an acceptable reaction/response to distressful situations. Make clear distinctions between positive accomplishments/qualities and the act of suicide. Focus on personal feelings and feelings of survivors. Express disappointment in deceased's decision and concern for survivors. Promote help-seeking and the Wingman concept. The goals are to: 1) Comfort the grieving; 2) Help survivors deal with guilt; 3) Help survivors with anger; 4) Encourage Airmen/family members to seek help; 5) Prevent "imitation" suicides.
15	Public memorials such as plaques, trees, or flags at half-mast may, in rare situations, encourage other at-risk people to attempt suicide in a desperate bid to obtain respect or adulation for themselves. Therefore, these types of memorials are not recommended.
16	Utilize or refer grieving co-workers to IDS community-based resources. For Military beneficiaries, consider Mental Health, Chaplain, Airman & Family Readiness, and Military One Source (1-800-342-9647). For civilians, consider Employee Assistance Program and follow-up services through TSR (consult with TSR team chief on details, if needed). If non-beneficiaries (i.e., extended family members, fiancé or boy/girlfriends) are struggling and asking for help, refer them to community-based services and/or discuss options with a mental health consultant or competent medical authority.
17	Ensure DoDSER completion and participate, as requested, with any appointed independent reviewer process (suicide review for installation/MAJCOM, or Medical Incident Investigation (MII). Avoid defensiveness. Acknowledge the processes are intended to determine if there are any 'lessons learned' in regards to suicide prevention, not to affix blame.
18	Anniversaries of suicide (1 month, 6 month, 1 year, etc.) are periods of increased risk. Promote healthy behaviors and the Wingman concept during these periods.

Guidance for Actions Following a Suicide Attempt

Purpose: This checklist is designed to assist leaders in regards to addressing suicide attempts by those in their unit. There can be many factors considered in a person's decision to attempt suicide, and the proper response to the attempt can diminish the risk factors for another attempt, and greatly aid in restoring the individual to the work center with minimal disruption.

1	As noted in the ***Air Force Leader's Guide for Post-Suicide Response PowerPoint*** (available at: http://airforcemedicine.afms.mil/idc/groups/public/documents/afms/ctb_151390.pdf) suicide is an act made by a person seeking relief from real or perceived pain. A person who makes a suicide attempt may have either (1) been prevented from making an action they intended to result in death; (2) not intended to die, but felt the need to demonstrate an attempt for others to know they are in pain; (3) been under the influence of drugs (including alcohol) which caused an impaired decision (often referred to as 'impulsive'); (4) been suffering from mental illness and extremely impaired but did not die as a consequence of the suicide plan.
2	Contact local law enforcement/Security Forces, AFOSI, and 911 (situation dependent). AFOSI Duty Agent can be contacted after hours through the Law Enforcement Desk or Command Post.
3	Notify First Sergeant, Command Post and Chain of Command. Command Post will initiate Operational Reporting (OPREP) messages. (Command Post will notify FSS/CL). Ensure notifications are kept to short list of "need to know" and contain minimum amount of information to convey nature of critical event. Being appropriate with "need to know" helps avoid stigmatizing the member's return to a work center where many people are aware of what happened.
4	If attempt was by an Airman in Title 10 status: Notify the nearest active duty Mental Health Clinic or Mental Health on-call provider to consult on safety planning, a fitness for duty determination and coordination of a possible Commander Directed Evaluation (CDE). If an attempt was by a civilian the Mental Health Clinic or on-call provider can provide guidance on options. Generally, civilian authorities and hospitals will be the lead agents for response to the attempt.
5	If the attempt has occurred in the workplace: Notify local law enforcement/Security Forces, AFOSI and Chain of Command. Ensure the area of the attempt has been secured and contact the nearest active duty Mental Health Clinic or Mental Health on-call provider or ARC equivalent for consultation and potential TSR activation.
6	A suicide attempt requires formal Mental Health assessment and often will result in hospitalization to stabilize the individual and ensure safety. If the member is hospitalized, it is recommended you consult with Mental Health and your Chain of Command regarding visiting the person while they are in the hospital.
7	Returning to work: A person who has experienced a crisis may find returning to work to be comforting (a sense of normalcy) or distressing. Work may need to be tailored to accommodate for medical/Mental Health follow-up appointments and assessed abilities of the person upon their return. The goal is to gradually return to full duties as appropriate. If Active Duty or ARC: Ensure the Airman is cleared for return to duty by Mental Health and their Primary Care Manager (PCM). PCM Consultation between Mental Health/PCM and Command can ensure a work schedule that accommodates the active duty member provides additional supervision and support without risk of showing secondary gain for having attempted suicide. Recommendations: 1. "No Drink" order 2. Non-weapons bearing duties 3. Secure personal weapons, providing a safe alternative (i.e., base armory) If civilian: Recommend discussing alcohol and weapons. Engage with employee to ensure they provide documentation indicating they are medically cleared by their treating medical/Mental Health provider to return to the work environment. Coordinate with Civilian Personnel Office on accommodations (if required) to work schedule and work environment.

8	A returning member must not be treated as fragile or 'damaged.' If they sense they are being 'singled out' or treated differently in the presence of peers, it can damage the recovery process. Freely speak with the employee about being receptive to their thoughts on returning to work and how to avoid either their, or your, perception of 'walking on egg shells.'
9	Consider leave requests carefully. Support the employee by ensuring leave requests involve structured time or planned events that will enhance them as they take time away from work. ARC leaders are encouraged to collaborate with civilian employers after obtaining permission from the member to do so.
10	Ensure all members of the unit are aware that seeking Mental Health is a sign of strength and helps protect mission and family by improving personal functioning instead of having personal suffering.
11	Never underestimate the power of the simple statement: "What can I do to be helpful to your recovery process?"
12	Consult with Mental Health providers to develop a supportive plan to re-integrate the Airman into the workplace.
13	Engage family and support networks to increase support and surveillance of the Airman. Encourage family and friends to reach out to the unit if they become concerned about the Airman's emotional state.
14	Ensure a DoDSER entry is completed for all suicide attempts which result in hospitalization or evacuation from the AOR.

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